HCD International
MDCTO-0085
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information	
Application ID Number	MDCTO-0085
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
Organization Site Name	HCD International
DBA Name	None
Website (if applicable)	www.hcdi.com
Ownership & Legal Structure	
Owned by Health Care Organization	No
Name of Parent Organization	N/A
Legal Structure	Profit corporation: Disadvantaged, Woman-Owned Small Business
Service Area	
Counties Served	Calvert County; Charles County; Frederick County; Montgomery County; Prince George's County; Saint Mary's County; Washington County
Partnerships	
Formal Partnerships	UMD Capital Region Health UMD Capital Region Health and Wellness Centers Prince George's County Agencies: Health Department, Fire/EMS, Social Services, Family Services Maryland Department of Corrections Problem Solving Court System MD TLC Regional Partnership Nexus Montgomery Regional Partnership Primary Care Coalition
Informal Partnerships	N/A
Services Offered	
Tele-diagnosis	Not a current or planned activity or service
Tele-behavioral health	Planned for future
Tele-consultation	Planned for future
Remote Monitoring	Not a current or planned activity or service
Other	N/A
HIT	
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.
HIT Product Name	Comprehensive Population Health Management Technology Platform
HIT Vendor	Health EC

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	4	N/A
Behavioral Health Counselor	N/A	4
Billing/Accounting Support	4	N/A
Care Managers - RNs	1	4
Care Managers - Medical Assistants	N/A	1
Care Managers – Other As Needed	N/A	4
Community Health Workers	12	4
Data Analysts	2	2
Health IT Support	4	N/A
Licensed Social Workers	1	11
Nutritionist	1	1
Pharmacists	1	1
Practice Transformation Consultants	4	N/A
Psychiatrist	N/A	1
Psychologist	N/A	1
Other	N/A	N/A

Vision

HCDI brings our success in developing strong, supportive, collaborative relationships is our work as a TCPI/SAN. In response to the next generation of clinical transformation, HCDI SAN was designed by physicians for physicians as a multi-cultural programmatic solution using the TCPI Five Phases of Practice Transformation to support Provider Transformation Networks (PTNs). The HCDI SAN brings the collaborative infrastructures of the National Hispanic Medical Association (NHMA), National Council of Asian Pacific Islander Physicians (NCAPIP), the National Association of American Indian Physicians (NAAIP), and the National Minority Quality Forum (NMQF) together as strategic partners. These minority physician membership organizations in large represent clinicians serving medically underserved rural and urban areas. The HCDI SAN has the distinctive ability through its existing channels of influence to educate, disseminate, peer-to-peer network, research, and implement evidence-based approaches for improving outcomes in support of the MDPCP. The average spend per person was 81 times higher for those in the very high risk category compared with the very low risk category. Service utilization is substantially higher among people in the high risk categories. People in the very high risk category had, on average: seven times more emergency admissions than those in moderate risk categories; three times the length of stay; two and a half times more primary care contacts; and 22 times more contacts with the community health system (Bestsennyy 2013). Longitudinal case management across the continuum of care provides guidance on establishing case management processes to bridge the gap between care settings such as ambulatory, acute, and post-acute with the goal of arming the patient with community resources to thrive at home. When it comes to creating a care-delivery system that precludes fragmentation of care, there is no “quick fix.” Such a monumental change requires a calculated, systematic approach to doing things differently, transforming an organization’s culture and practice and maintaining commitment to change. HCDI follows the Elsevier Clinical Practice Model Framework The Framework is supported by core beliefs, principles, theories and healthcare best practices that have been synthesized into concise models to effect change that leads to positive outcomes for patients and their families, caregivers and the healthcare community at large. The six inter-related models of care are intentionally designed, evidence-based, action-oriented, and outcome focused. They also are team-focused, technology-enabled, scalable and capacity building for a solid foundation for change. The impact of using this model has demonstrated: Improved process efficiency resulting in improved staff engagement, More efficient transitions of care, Reduces errors, unnecessary tests and procedures, omissions of care, Reduced readmissions, Improved overall patient experience due to better care, more efficient process and personal connection with healthcare providers, Satisfying work life culture, Improved patient engagement HCDI has extensive experience providing technical assistance to practices as they transition to a value based payment system. In addition to the required care management activities, HCDI offers implementation experience with assessment instruments that fulfill Track 2 Practice requirements including our social determinants of health collection tool “Caring For Your Health” available to all practices who participate with HCDI.

Approach to Care Delivery Transformation

A key first step is to remove the complexity that has resulted from different policy initiatives over the years. A simple pattern of services has been be developed, based around primary care and natural geographies and with a multidisciplinary team. These teams will work in new ways with specialist services-- both community and hospital based, to offer patients a much more complete and less fragmented service. Our model will include both mental health and social care, including the management of the health and social care cost for the care of their patients. These services need to be capable of a very rapid response and to work with hospitals to speed up discharge. The opportunity to harness the power of the wider community to support people in their own homes, combat social isolation and improve prevention is not being fully exploited. There has been a longstanding ambition to shift more health care from hospitals to settings closer to people's homes, and from reactive care to prevention and proactive models based on early intervention. There is an emerging consensus about the impact that community services can have and what is needed to improve their effectiveness. The main steps identified are: reduce complexity of services, wrap services around primary care. build multidisciplinary teams for people with complex needs, including social care, mental health and other services, support these teams with specialist medical input and redesigned approaches to consultant services-- particularly for older people and those with chronic conditions, create services that offer an alternative to hospital stay, build an infrastructure to support the model based on these components including much better ways to measure and pay for services, develop the capability to harness the power of the wider community. Care coordinators and navigators, single points of access and other interventions can help to deal with this.